POC PROVIDER AGREEMENT for
WEEKLY LONG TERM–PERSONAL CARE SERVICES / ELDERLY and DISABLED ADULT WAIVER–COMPANION SERVICES / ADULT DAY HEALTH CARE SERVICES

SUPPORT COORDINATION OR SINGLE POINT OF ENTRY AGENCY NAME & TELEPHONE #: XYZ, Inc. 225-123-4567
PARTICIPANT NAME: Melvin Joseph Brown **MEDICAID ID #:** 12345788900000 **DATE DEVELOPED:** 3-13-09

This Participant Schedule is subject to change depending on the participant's preferences and fluctuations in his/her personal schedule. Therefore the anticipated schedule on the approved POC Task List and/or POC and Individualized Service Plan shall not be used for audit or monitoring purposes. Weekly allocations are to be used flexibly, in accordance with the participant's preferences and personal schedule within the week that begins on Sunday @ 12:00 a.m., and ends on the following Sunday @ 12: 00 a.m. Allocations are to be used within the prescribed week only. Unused portions of a weekly allocation cannot be saved or borrowed from one week for use in another week. Total hours used within the week may not exceed the prior authorized weekly allocation. Total number of days of ADHC attendance may not exceed the prior authorized weekly allocation.

x Betty M. Brown 3-13-09
☐ Participants or ☒ Personal Representative's Signature and Date

x Sue Coordinator Sue Coordinator 3-13-09
Support Coordinator's or Assessor's Printed Name and Signature and Date

☒ We agree to provide services/supports in accordance with the approved POC Task List and/or POC and Individualized Service Plan. Completion of the provider number(s) section(s) below denotes type(s) of service to be provided.

*If you (Provider) do not agree to provide services/supports in accordance with the approved POC Task List and/or POC and Individualized Service Plan, you must submit written documentation that supports your inability to meet the individual's health and welfare needs, or to support that all previous efforts to provide services/supports have failed, and that there is no option but to refuse service provision.

☐ If not agreeing to provide services to this participant, I (Provider) have attached requested information.

x Good Care, Inc.	XXXXXXX	XXXXXXX	
Provider Agency Printed Name and Numbers	LT-PCS Provider #	EDA-CS Provider #	ADHC Provider #
x			
2nd Provider Agency Printed Name and Numbers (if applicable)	LT-PCS Provider #	EDA-CS Provider #	ADHC Provider #

x Jon Supporter, Operations Director Jon Supporter 3-17-09
Pre-Approval Provider Agency Representative Printed Name and Title and Signature and Date

x
2nd Pre-Approval Provider Agency Representative Printed Name and Title and Signature and Date (if applicable)

x Bonnie Williams 3-26-09
OAAS Regional Office Representative Approval Signature and Date

x Jane Smith, Operations Supervisor Jane Smith 3-30-09
Post-Approval Provider Agency Representative Printed Name and Title and Signature and Date

x
2nd Post-Approval Provider Agency Representative Printed Name and Title and Signature and Date (if applicable)